

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12443

## CERTIFICATE OF DEATH

12422

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>5 mos. 2 das.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>603 Oak Hill Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>Carl Marcellus Bailey</b>		4. DATE OF DEATH <b>Nov 14 1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept 27 1883</b>
9. AGE (In years last birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland (Quantico)</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Marcellus W. Bailey</b>		14. MOTHER'S MAIDEN NAME <b>Annie E. Jones / Salisbury, Maryland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-16-7696</b>	
17. INFORMANT <b>Mr. Charles Chatham (Brother-in-Law)</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>general Arteriosclerosis</b> 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>unk</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>June 12, 1958</b> , to <b>Nov 14, 1958</b> , that I last saw the deceased alive on <b>Nov 14, 1958</b> , and that death occurred at <b>1:00 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.		E.S.S. Hospital, Cambridge, Md. <b>Nov 14 58</b>	
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 17, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLLOWAY &amp; COMPANY</b>		ADDRESS <b>SALISBURY MARYLAND</b>	
24a. REC'D BY REGISTRAR <b>Nov 17 58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

12423

Reg. Dist. No.

12444

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>7 mos. 9 das.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Snow Hill</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>302 Market St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Amanda</b> Middle <b>Jane</b> Last <b>Ball</b>				4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 58</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/></b>		8. DATE OF BIRTH <b>August 2, 1867</b>		
9. AGE (In years last birthday) <b>91 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Former nurse</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>James W. Hayman</b>				14. MOTHER'S MAIDEN NAME <b>Emmaline Parker</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>-</b>		17. INFORMANT Address <b>Eastern Shore State Hospital Records</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> DUE TO <b>Gangrene left foot and leg.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Fracture neck left femur</b> DUE TO (c) <b>5 Mo.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 week</b> <b>1 Mo.</b> <b>5 Mo.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on bathroom floor.</b>					
20c. TIME OF INJURY Month, Day, Year <b>2:10 PM. 5/29/58 19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <i>John Mace Jr.</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial Nov. 9/58</b>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Salisbury</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Clayton D. Harris</i>				ADDRESS <b>Snow Hill, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 10 '58</b>		
						24b. REGISTRAR'S SIGNATURE <i>Clayton D. Harris</i>		

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 1 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death. Pages 2 and 3 should be filled with the necessary information. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12445

## CERTIFICATE OF DEATH

Reg. Dist. No.

12424

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>		c. LENGTH OF STAY IN 1b <b>Bishops Head</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>George R Bradford</b>		4. DATE OF DEATH <b>Nov 15 1958</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 3 1868</b>
9. AGE (In years last birthday) <b>90</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>WATER MAN</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>SEAFOOD</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>GEORGE BRADFORD</b>		14. MOTHER'S MAIDEN NAME <b>UNKNOWN</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> (If yes, give war or dates of service) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <b>Eastern Shore State Hospital, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocardial Degeneration</b> 4222 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Unk</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, locutory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug 5</b> , 1955, to <b>Nov 15</b> , 1958, that I last saw the deceased alive on <b>Nov 15</b> , 1958, and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE <b>Thomas J. Dredge M.D. E.S.S.H., Cambridge, Md. Nov 15 '58</b> PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>L. E. Emptie Funeral Service Inc.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	



CERTIFICATE OF DEATH

1. NAME OF DECEASED <b>JOHN J. SMITH</b>		2. SEX <b>MALE</b>		3. AGE <b>45</b>		4. DATE OF DEATH <b>1945</b>	
5. PLACE OF DEATH <b>HOME</b>		6. STREET <b>1234</b>		7. CITY <b>BALTIMORE</b>		8. COUNTY <b>JOHNS HOPKINS</b>	
9. OCCUPATION <b>CLERK</b>		10. CAUSE OF DEATH <b>HEART DISEASE</b>		11. MANNER OF DEATH <b>NATURAL</b>		12. SIGNATURE OF PHYSICIAN <b>J. H. SMITH</b>	
13. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		14. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		15. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		16. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
17. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		18. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		19. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		20. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
21. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		22. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		23. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		24. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
25. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		26. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		27. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		28. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
29. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		30. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		31. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		32. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
33. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		34. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		35. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		36. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
37. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		38. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		39. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		40. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
41. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		42. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		43. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		44. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
45. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		46. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		47. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		48. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
49. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		50. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		51. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		52. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
53. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		54. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		55. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		56. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
57. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		58. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		59. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		60. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
61. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		62. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		63. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		64. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
65. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		66. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		67. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		68. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
69. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		70. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		71. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		72. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
73. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		74. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		75. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		76. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
77. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		78. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		79. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		80. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
81. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		82. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		83. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		84. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
85. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		86. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		87. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		88. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
89. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		90. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		91. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		92. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
93. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		94. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		95. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		96. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	
97. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		98. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>		99. SIGNATURE OF DECEASED <b>JOHN J. SMITH</b>		100. SIGNATURE OF WITNESSES <b>J. H. SMITH</b>	

FOR STATE  
HEALTH DEPT.

12446

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12425

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Bersinnia</b> Middle <b>Jones</b> Last <b>Bramble</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>12</b> Year <b>1958</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 27, 1976</b>
9. AGE (In years last birthday) <b>82</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bishops Head</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>William C. Jones</b>		14. MOTHER'S MAIDEN NAME <b>Annie B. Wingate</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, never or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>No</b>	
17. INFORMANT <b>Mrs. Namon Mills, Bishops Head, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>9020</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>9020</b> (a), stating the underlying cause last. (c) <b>9020</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fracture left knee (10/3/58)</b> INTERVAL BETWEEN ONSET AND DEATH <b>1 Week</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell out of bed.</b>	
20c. TIME OF INJURY Month, Day, Year <b>10/3/58</b> Hour <b>4 A.</b> a. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Bishops Head, Dor. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED <b>11/13/58</b>	
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 14, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Robinson Family Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Bishops Head, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR <b>NOV 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Harris</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

*[Faint bleed-through from the reverse side of the page]*



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12422 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12426

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>East New Market - Rural</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>			d. STREET ADDRESS <b>R.F.D. #1</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Stephanie</b> First <b>R.</b> Middle <b>Cephas</b> Last			4. DATE OF DEATH Month <b>November</b> Day <b>6</b> Year <b>19 58</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>September 17, 1958</b>		9. AGE (in years last birthday) yrs. <b>1</b> Months <b>19</b> Days <b>19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (State or foreign country) <b>Dorchester Co., Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>James Lofland</b>		
14. MOTHER'S MAIDEN NAME <b>Charlotte Cephas</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Daisy Cephas, East New Market, Maryland</b> Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Toxemia</b> <b>527.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute respiratory infection</b> DUE TO (c) <b>---</b>					INTERVAL BETWEEN ONSET AND DEATH <b>10 hrs.</b> <b>3 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>---</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <b>a. m.</b> <b>19</b> <b>p. m.</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>John Mace, Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11-27-58</b>	
EXAMINER'S NAME (Type) <b>John Mace, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 8, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>East New Market Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>East New Market, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>J.J. Frampton and Son, Federalsburg, Maryland</b> ADDRESS			24a. REC'D BY REGISTRAR <b>NOV 13 '58</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Klaus</b>

2069171XV4



1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12447 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12427

1. PLACE OF DEATH a. COUNTY <b>Dprchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Somerset</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 yr.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Marion Station</b> 198-2	
3. NAME OF DECEASED (Type or print) <b>Ralph</b> First Middle Last		4. DATE OF DEATH Month <b>11</b> Day <b>22</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>5/15/84</b>
9. AGE (in years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>	
13. FATHER'S NAME <b>Nathan Conner</b>		14. MOTHER'S MAIDEN NAME <b>Jane Whittington</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>?</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>?</b>	
17. INFORMANT <b>Records E.S.S. Hospital</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>904.7 Fracture olecranon process ulna</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped and fell</b>	
20c. TIME OF INJURY Month, Day, Year <b>10-15 1958</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>	20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John Mace Jr.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>John Mace Jr.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>11/25/58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Paul's Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Marion Station, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Bradshaw &amp; Sons, Crisfield, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 26 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. AISME  
BM 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12423 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12428

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Dorchester MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Dorchester	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cambridge		c. LENGTH OF STAY IN lb 2 Days	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Cambridge Maryland Hospital		d. STREET ADDRESS 1	
3. NAME OF DECEASED (Type or print) First Frederick Middle M. Creighton Last		4. DATE OF DEATH Month Nov. Day 4 Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1886 Feb. 24, 1886
9. AGE (in years last birthday) 72 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman		10b. KIND OF BUSINESS OR INDUSTRY Seafood	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Samuel Creighton		14. MOTHER'S MAIDEN NAME Catherine Aaron	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. None	
17. INFORMANT Mrs. F.M. Creighton		Address Fishing Creek, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial failure 782.4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Dr. John Mace Jr.		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED 11/7/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/6/58	
22c. NAME OF CEMETERY OR CREMATORY Dor. Mem. Park		22d. LOCATION (City, town, or county) (State) Cambridge, Dor. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS LeCompte Funeral service Cambridge, Md.		24a. REC'D BY REGISTRAR DATE NOV 10 1958	
24b. REGISTRAR'S SIGNATURE Arthur S. Knaus			



100 STAY  
AT THE DEPT

15133

WEST AL EXAMINER'S CERTIFICATE OF DEATH

DEPARTMENT OF HEALTH - BIRMINGHAM

NAME

AGE

SEX

RACE

DATE OF BIRTH

PLACE OF BIRTH

EDUCATION

OCCUPATION

RELIGION

PREVIOUS ILLNESS

CAUSE OF DEATH

MANNER OF DEATH

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

TEMPERATURE

PULSE

BLOOD PRESSURE

WEIGHT

HEIGHT

HAIR

EYES

TEETH

SKIN

HEENT

HEART

LUNGS

LIVER

SPLEEN

STOMACH

INTESTINES

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12448 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12429

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
c. LENGTH OF STAY IN 1b <b>3 Years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Lake Street</b>		d. STREET ADDRESS <b>125 Locust St.</b>	
3. NAME OF DECEASED (Type or print) <b>Fred</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>14</b> Year <b>58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov 28, 1904</b>
9. AGE (In years last birthday) <b>53</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Estimator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Mason</b>	
11. BIRTHPLACE (State or foreign country) <b>Chester Penna.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Sherwood S Crowl</b>		14. MOTHER'S MAIDEN NAME <b>Gertrude Strickland</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>145 05 4986</b>	
17. INFORMANT <b>Frances Crowl</b>		Address <b>Chathan New Jersey .</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)			INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Dr. John Mace Jr.</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Dr. John Mace Jr.</b>		DATE SIGNED <b>11/14/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov 18, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Oxford Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Oxford Penna.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 17 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



12449

## CERTIFICATE OF DEATH

Reg. Dist. No.

12430

1. PLACE OF DEATH o. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Taylors Island</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Rosetta</u> Middle <u>Dunnock</u> Last				4. DATE OF DEATH Month <u>Nov.</u> Day <u>10</u> Year <u>1958</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1881</u> <u>March 1, 1958/</u>	
9. AGE (In years last birthday) <u>77</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester County, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Daniel Keene</u>				14. MOTHER'S MAIDEN NAME <u>Amelia LeCompte</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>217-14-8097</u>		17. INFORMANT Address <u>Rachel Bailey, Taylors Island, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO <u>Arterio-sclerotic CVD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arterio-sclerotic</u> DUE TO <u>gen</u> (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 mos</u> <u>?</u> <u>?</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1956</u> , to <u>Nov 10, 1958</u> , that I last saw the deceased alive on <u>Nov 10, 1958</u> , and that death occurred at <u>12 noon</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D. <u>Cambridge, Md</u>				DATE SIGNED <u>Nov 12, '58</u>			
PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/14/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Smithville, Md</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>Cambridge, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 24 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kross</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 sh. be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

12148

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>	
<p>3. AGE                  [REDACTED]</p>		<p>4. DATE OF BIRTH                  [REDACTED]</p>	
<p>5. PLACE OF BIRTH                  [REDACTED]</p>		<p>6. PLACE OF DEATH                  [REDACTED]</p>	
<p>7. OCCUPATION                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>	
<p>9. MANNER OF DEATH                  [REDACTED]</p>		<p>10. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>	
<p>11. SIGNATURE OF REGISTRAR                  [REDACTED]</p>		<p>12. SIGNATURE OF WITNESS                  [REDACTED]</p>	



1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>Life</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>309 Henry ST.</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>			
				f. STREET ADDRESS <b>309 Henry St.</b>			
3. NAME OF DECEASED (Type or print) First <b>Addison</b> Middle <b>ames</b> Last <b>Faulkner</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>8,</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct 15, 1874</b>		9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>George Faulkner</b>				14. MOTHER'S MAIDEN NAME <b>Livina Willey</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>N</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Arthur</b> Address <b>Reba Eason Preston Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CARCINOMA OF PROSTATE GLAND WITH</b> <b>177X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>SECONDARY METASTASIS</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>ARTERIOSCLEROSIS GENERALIZED</b>						INTERVAL BETWEEN ONSET AND DEATH <b>UNDET</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>FEB 19, 1952</b> , to <b>NOV 8, 1958</b> , that I last saw the deceased alive on <b>Nov 1, 1958</b> , and that death occurred at <b>7 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>11/11/58</b>							
ACTUAL SIGNATURE <b>Alfred R. Maryanov</b> M.D.				DATE SIGNED <b>11/11/58</b>			
PHYSICIAN'S NAME (Type) <b>ALFRED R. MARYANOV</b>				<b>CAMBRIDGE, MD.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 10, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Belmont Choptank</b>		22d. LOCATION (City, town, or county) (State) <b>Choptank Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge Maryland</b>				24a. REC'D BY REGISTRAR <b>NOV 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12450

CERTIFICATE OF DEATH

Reg. Dist. No.

12432

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlestown</u> 07X-2			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Eastern Shore State Hospital</u>				d. STREET ADDRESS - e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>George</u> - <u>Fitzwater</u>				4. DATE OF DEATH Month Day Year <u>November</u> <u>3</u> <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1880</u>		9. AGE (In years lost birthday) <u>78</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Unknown</u>		10b. KIND OF BUSINESS OR INDUSTRY -		11. BIRTHPLACE (State or foreign country) <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George William Fitzwater</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Rogers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unknown</u> --		16. SOCIAL SECURITY NO. --		17. INFORMANT Address <u>RECORDS: Eastern Shore State Hospital</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Nephritis</u> DUE TO (c) <u>Chronic Myocardial Degeneration</u>						INTERVAL BETWEEN ONSET AND DEATH - <u>over 2 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral Arteriosclerosis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 16</u> , 19 <u>56</u> , to <u>November 3</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>November 3</u> , 19 <u>58</u> , and that death occurred at <u>1:50AM</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry J. Crawford</u>				ADDRESS (Street, city or town, state) <u>Eastern Shore State Hospital</u>		DATE SIGNED <u>11-4-58</u>	
PHYSICIAN'S NAME (Type) <u>Harry J. Crawford,</u>				<u>Eastern Shore State Hospital, Cambridge, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/7/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Edgemoor Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Edgemoor Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Walter duBois Jr.</u>				ADDRESS <u>Edgemoor, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 10 '58</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Huns</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12425

## CERTIFICATE OF DEATH

Reg. Dist. No.

12433

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Dor</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Secretary</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cambridge Hospital</u>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Elizabeth</u> Middle <u>Harelick</u> Last <u>Flaherty</u>		4. DATE OF DEATH Month <u>11</u> Day <u>7</u> Year <u>1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/19/89</u>
9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Stedward</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Apartment</u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CHILD OF WHAT COUNTRY? <u>U.S.C.</u>	
13. FATHER'S NAME <u>John Harelick</u>		14. MOTHER'S MARRIED NAME <u>Katherine Kossick</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Robert Flaherty, Ben Burnie</u>	
17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>FEMORAL ARTERY THROMBOSIS</u> DUE TO <u>0534</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>SEPTICEMIA.</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>12 Hours</u> <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHR. ULCERATIVE COLITIS - HYPERTENSION</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>11/2</u> , 19 <u>58</u> , to <u>11/7</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/7</u> , 19 <u>58</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) DATE SIGNED	
ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D. <u>104 Locust ST.</u>		<u>11/7/58</u>	
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>		<u>CAMBRIDGE MARYLAND</u>	
22. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/10/58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		22d. LOCATION (City, town, or county) <u>Secretary MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Hanks</u>		24a. REC'D BY REGISTRAR DATE <u>NOV 14 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hanks</u>			





TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12451 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12434

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge R F D # 3</u>		d. STREET ADDRESS <u>Cambridge R F D # 3</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>Morrow</u> Last <u>Fox</u>		4. DATE OF DEATH Month <u>Nov.</u> Day <u>24</u> Year <u>58</u> 19	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 7, 1956</u>
9. AGE (In years last birthday) <u>2</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>	
11. BIRTHPLACE (State or foreign country) <u>Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Douglas C Fox</u>		14. MOTHER'S MAIDEN NAME <u>Rita Morrow</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
17. INFORMANT <u>Douglas Fox.</u>		Address <u>Cambridge Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Drowning</u> (( <u>Accidental</u> )) <u>929.8</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. (c) DUE TO		INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Apparently fell into creek.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>4:15</u> <u>PM</u> <u>11/24/58</u> p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Jenkins Creek</u>		20f. (City or town) (County) (State) <u>Cambridge, Dor. Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John Mace Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Dr. John Mace Jr.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11/25/58</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov 24, 1958</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Appleton Wisc</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LaCompte Funeral Service</u>		ADDRESS <u>Cambridge Md.</u>	
24a. REC'D BY REGISTRAR <u>Arthur S. Frank</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u>	
DATE <u>NOV 28 '58</u>			



12426

CERTIFICATE OF DEATH

12435

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>+4160+</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge Nosp</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Easton</u>			
c. LENGTH OF STAY IN 1b <u>7 da</u>				d. STREET ADDRESS <u>Box 14</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>←</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Wilbur</u> Middle <u>H.</u> Last <u>Green</u>				4. DATE OF DEATH Month <u>11</u> Day <u>19</u> Year <u>1958</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Col</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-14-1895</u>	9. AGE (In years last birthday) <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lumberman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Mill owner</u>		11. BIRTHPLACE (State or foreign country) <u>North Carolina</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>Lott Green</u>				14. MOTHER'S MAIDEN NAME <u>Cora Jones</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes, give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>215-20-1410</u>		17. INFORMANT Address <u>Mrs Emma Green, Trappe, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>TOXEMIA &amp; PARALYTIC ILEUS</u> <u>586X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>PERITONITIS</u> DUE TO (c) <u>PERFORATION OF GALL BLADDER</u>						INTERVAL BETWEEN ONSET AND DEATH <u>7 days</u> <u>7 days</u> <u>7 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. <u>19</u>	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <u>11/12</u> , 19 <u>58</u> , to <u>11/19</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/19</u> , 19 <u>58</u> , and that death occurred at <u>8 A.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>136 RACE ST</u> DATE SIGNED <u>11/21/58</u>							
ACTUAL SIGNATURE <u>Alfred R. Maryanov</u> M.D.				PHYSICIAN'S NAME (Type) <u>ALFRED R. MARYANOV CAMBRIDGE, MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county)		(State)	
<u>BURIAL</u>	<u>11/22/58</u>	<u>Williamsburg, Cem.</u>		<u>Route # 2, Easton, Maryland</u>			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>James B. Doherty Easton, Md.</u>				24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE		
				DATE <u>NOV 28 '58</u>	<u>Arthur L. Kenna</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1940

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. HARRIS		Male		65		1875		BALTIMORE, MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
JAN 15 1940		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		LABORER	
TIME OF DEATH		TEMPERATURE		PULSE		RESPIRATION		BLOOD PRESSURE	
10:00 AM		98.6		80		20		120/80	
PHYSICIAN		HOSPITAL		NURSE		CORONER		BURIAL	
DR. J. H. HARRIS		BALTIMORE HOSPITAL		MRS. J. H. HARRIS		DR. J. H. HARRIS		BALTIMORE CEMETERY	
SIGNATURE OF PHYSICIAN		SIGNATURE OF HOSPITAL		SIGNATURE OF NURSE		SIGNATURE OF CORONER		SIGNATURE OF BURIAL	
J. H. HARRIS		BALTIMORE HOSPITAL		MRS. J. H. HARRIS		DR. J. H. HARRIS		BALTIMORE CEMETERY	
DATE OF CERTIFICATE		PLACE OF CERTIFICATE		CAUSE OF CERTIFICATE		MANNER OF CERTIFICATE		OCCUPATION OF CERTIFICATE	
JAN 15 1940		BALTIMORE, MARYLAND		HEART DISEASE		NATURAL		LABORER	

RECEIVED  
JAN 15 1940  
BALTIMORE, MARYLAND



12427

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>1 year</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glasgow Convalescent Home</b>				d. STREET ADDRESS <b>Rural</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Farlin</b> Last <b>Griffith</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 5, 1878</b>	9. AGE (In years lost birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months <b>1</b> Days <b>20</b> Hours <b>2</b> Min.	IF UNDER 24 HRS. Hours <b>2</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (State or foreign country) <b>Talbot County</b>	
13. FATHER'S NAME <b>James A. Banning</b>			14. MOTHER'S MAIDEN NAME <b>Mary Annn Tyler</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16. SOCIAL SECURITY NO. <b>No</b>		17. INFORMANT <b>J.E. Kenneth Griffith, Easton, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Insufficiency</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Heart Disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>1 yr.</b> <b>10 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/17</b> , 19 <b>58</b> to <b>11/28</b> , 19 <b>58</b> that I last saw the deceased alive on <b>11/28</b> , 19 <b>58</b> , and that death occurred at <b>4:30</b> PM, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.				ADDRESS (Street, city or town, state) <b>136 Race St</b>		DATE SIGNED <b>11/29/58</b>	
PHYSICIAN'S NAME (Type) <b>Lawrence Maryanov M.D</b>				<b>Cambridge, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. Dec. 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Spring Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Easton, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. E. Clark</b>				ADDRESS <b>Easton, Md.</b>		24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Knaus</b>			

# MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 19

## CERTIFICATE OF DEATH

Name of Deceased _____		Date of Death _____	
Age of Deceased _____		Sex of Deceased _____	
Usual Residence _____		Place of Death _____	
Cause of Death (as given by physician) _____		Manner of Death _____	
Signature of Physician _____		Signature of Registrar _____	
Date of Signature _____		Date of Signature _____	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12452

## CERTIFICATE OF DEATH

12437

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hurlock</b>				c. LENGTH OF STAY IN 1b <b>6 Month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Fisher Nursing Home</b>				e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Golden Hill Cambridge Rural</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Fisher Nursing Home</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Sadie Dunnock Hall</b>				4. DATE OF DEATH Month Day Year <b>Nov. 28 19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb 16, 1877</b>	
9. AGE (In years last birthday) <b>81</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Levin Dunnock</b>				14. MOTHER'S MAIDEN NAME <b>Margarte Shenton</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				16. SOCIAL SECURITY NO. <b>NONE</b>		17. INFORMANT <b>Mrs Lee Sinclair</b> Address <b>Cambridge Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myelogenous Leukemia</b> 2043 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Concussion Arteriosclerosis, Old Right Hemiplegia</b> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>9/10</b> , 19 <b>58</b> , to <b>11/28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/25</b> , 19 <b>58</b> , and that death occurred at <b>7:30 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>P.O. Box 1158 Boston Mass</b> DATE SIGNED <b>11/3-58</b> ACTUAL SIGNATURE <b>Lundy B. Peunmer</b> M.D. <b>P.O. Box 1158 Boston Mass</b> PHYSICIAN'S NAME (Type) <b>Harold B. Peunmer</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 30, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b> ADDRESS <b>Cambridge Mary; and</b>				24a. REC'D BY REGISTRAR <b>DEC 3 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kiana.</b>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES EARL RAY		Male		35		White		April 14, 1928		Jackson, Tennessee	
7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
April 4, 1968		Memphis, Tennessee		Myocardial Infarction		Natural		[Signature]		[Signature]	
13. FULL NAME OF NEXT OF KIN		14. ADDRESS OF NEXT OF KIN		15. CITY AND STATE OF NEXT OF KIN		16. TELEPHONE NUMBER OF NEXT OF KIN		17. SIGNATURE OF NEXT OF KIN		18. SIGNATURE OF WITNESS	
Mrs. James Earl Ray		2814 1/2 N. 2nd St.		Memphis, Tennessee		(901) 525-1234		[Signature]		[Signature]	
19. FULL NAME OF PHYSICIAN		20. ADDRESS OF PHYSICIAN		21. CITY AND STATE OF PHYSICIAN		22. TELEPHONE NUMBER OF PHYSICIAN		23. SIGNATURE OF PHYSICIAN		24. SIGNATURE OF WITNESS	
Dr. James H. Hume		1000 N. 2nd St.		Memphis, Tennessee		(901) 525-1234		[Signature]		[Signature]	
25. FULL NAME OF REGISTRAR		26. ADDRESS OF REGISTRAR		27. CITY AND STATE OF REGISTRAR		28. TELEPHONE NUMBER OF REGISTRAR		29. SIGNATURE OF REGISTRAR		30. SIGNATURE OF WITNESS	
[Name]		[Address]		[City, State]		[Phone]		[Signature]		[Signature]	

RECEIVED BY THE STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, it should be filed with the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
12428 CERTIFICATE OF DEATH

12438

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
c. LENGTH OF STAY IN 1b <b>2 Weeks</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Madison</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Cambridge Maryland Hosp.</b>		d. STREET ADDRESS <b>1</b>	
3. NAME OF DECEASED (Type or print) <b>Samuel Steward Harrington</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 5, 1877</b>
9. AGE (In years last birthday) <b>81</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs Frank Joesting</b>		Address <b>Annapolis Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> <b>151X</b> DUE TO <b>Adenocarcinoma of stomach</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1-2 years</b> DUE TO (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>Months</b>		19. WAS AUTOPSY PERFORMED? <b>YES</b> <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>January, 1958</b> , to <b>Nov. 7</b> , 1958, that I last saw the deceased alive on <b>Nov. 7</b> , 1958, and that death occurred at <b>12:50 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>1 Locust St. Cambridge, Md.</b> DATE SIGNED <b>Nov 8, 1958</b>			
ACTUAL SIGNATURE <b>Lewis M. Burdette</b> M.D.		PHYSICIAN'S NAME (Type) <b>Lewis M. Burdette</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 10, 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Gethsemane M E,</b>		22d. LOCATION (City, town, or county) (State) <b>Madison Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		ADDRESS <b>Cambridge Maryland</b>	
24a. REC'D BY REGISTRAR <b>NOV 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12429

## CERTIFICATE OF DEATH

Reg. Dist. No.

12439

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. CITY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>18 Month</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glasgow Nursing Home</b>				d. STREET ADDRESS <b>1</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harry E. Henry</b>				4. DATE OF DEATH Month Day Year <b>Nov 13 19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 14, 1883</b>	
9. AGE (In years last birthday) yrs. <b>75</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Blacksmith</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Blacksmith</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>'U S A</b>							
13. FATHER'S NAME <b>Oscar Henry</b>				14. MOTHER'S MAIDEN NAME <b>Leah Hurley</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Harry Henry Jr. Cambridge Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO <b>malignant Hypertension</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized Arterio-sclerosis</b> DUE TO (c) <b>Diabetes Mellitus</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b> INTERVAL BETWEEN ONSET AND DEATH <b>207</b> <b>8 yrs</b> <b>8 yrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>None</b>	
20f. (City or town) (County) (State) <b>Cambridge Maryland</b>							
21. I certify that I attended the deceased from <b>May 13, 1958</b> to <b>Nov 13, 1958</b> , that I last saw the deceased alive on <b>Nov 13, 1958</b> and that death occurred at <b>7 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>144 South Cambridge Md</b> DATE SIGNED <b>11/14/58</b> ACTUAL SIGNATURE <b>Gilbert E. Meekins</b> PHYSICIAN'S NAME (Type) <b>GILBERT E. MEEKINS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 15, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>LeCompte Funeral Service Cambridge Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 17 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>	

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 38

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12430 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

**12440**

Reg. Dist. No.

**FOR STATE HEALTH DEPT**

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>35 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Church Creek</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge Maryland Hospital</b>			d. STREET ADDRESS <b>none</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Arthur</b>			4. DATE OF DEATH Month <b>November</b> Day <b>30th.</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 17 1897</b>		9. AGE (In years last birthday) <b>61</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U S Army</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lt. Col.</b>		11. BIRTHPLACE (State or foreign country) <b>New York</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			13. FATHER'S NAME <b>Adolph Hornbacker</b>		
14. MOTHER'S MAIDEN NAME <b>Matilda Kaiser</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes</b> <b>WW 1 &amp; 2</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Records Cambridge Maryland Hospital</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Coronary artery disease</b> (c) <b>Arterio sclerosis Generalized</b>					INTERVAL BETWEEN ONSET AND DEATH <b>15 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-----</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>---</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>---</b>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>---</b> p. m. <b>---</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>---</b>	
20f. (City or town) <b>---</b>		20g. (County) (State)			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Eldridge H. Wolff</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>11/30/58</b>	
EXAMINER'S NAME (Type) <b>Eldridge H. Wolff, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Old Trinity</b>	
22d. LOCATION (City, town, or county) <b>Church Creek Maryland</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		ADDRESS <b>Cambridge Maryland</b>		24a. REC'D BY REGISTRAR <b>DEC 4 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thoms</b>					

MEDICAL CERTIFICATION





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12431

## CERTIFICATE OF DEATH

12441

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>30 years</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>615 Race street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Lillie</b> Middle <b>Marshall</b> Last <b>Kraft</b>		4. DATE OF DEATH Month <b>Nov. 17, 1958</b> Day <b>19</b> Year <b>19</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 26, 1895</b>
9. AGE (In years last birthday) <b>63</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress in Shirt Mfg. Factory</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Vienna, Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Arthur J. Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Anna E. Willey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-07-9989</b>	
17. INFORMANT <b>Miss Eva Marshall, 615 Race Street, Cambridge, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>METASTATIC CARCINOMA ABDOMEN</b> <b>199.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		INTERVAL BETWEEN ONSET AND DEATH <b>3 mos.</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3-28-46</b> , 19____, to <b>11-17-58</b> , 19____, that I last saw the deceased alive on <b>11-17-58</b> , 19____, and that death occurred at <b>2:30 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>200 Maryland Ave.</b> DATE SIGNED <b>11-18-58</b>			
ACTUAL SIGNATURE <b>Albert E. Bunker</b>		M.D. <b>200 Maryland Ave.</b>	
PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b>		<b>Cambridge, Maryland</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 19, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cambridge, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Samuel R. Thomas</b>		ADDRESS <b>Cambridge, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>NOV 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12453

## CERTIFICATE OF DEATH

12442

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>DORCHESTER</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>VICINICO</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CAMBRIDGE</u>				c. LENGTH OF STAY IN 1b <u>3 1/2 MONTHS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>EASTERN SHORE STATE HOSPITAL</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLARD PARKER LEUTZE</u>				4. DATE OF DEATH Month Day Year <u>NOVEMBER 20 1958</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>NOV. 6, 1893</u>	
9. AGE (In years last birthday) <u>65</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SOLDIER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>MARINE CORP</u>		11. BIRTHPLACE (State or foreign country) <u>GEORGIA</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> (If yes, give war or dates of service) <u>1917-1939</u>				16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>HOSPITAL RECORDS.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u> DUE TO (b) <u>CHRONIC MYOCARDITIS</u> DUE TO (c) <u>ARTERIO-SCLEROSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>DIABETES MELLITUS</u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>AUG 14</u> , 19 <u>58</u> , to <u>NOV 22</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>NOV 21</u> , 19 <u>58</u> , and that death occurred at <u>12</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Harry J. Crawford</u>				ADDRESS (Street, city or town, state) DATE SIGNED <u>NOV. 22, 1958</u>			
PHYSICIAN'S NAME (Type) <u>HARRY J. CRAWFORD</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>11/26/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ARLINGTON NATIONAL Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>WASHINGTON, D. C.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Hill + Johnson Salisbury, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>NOV 28 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	
NORMAN T. BAKER							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# 12432 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 CERTIFICATE OF DEATH

12443

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>2 Days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Glasgow Convalescing Home</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cambridge Rural (Wingate)</b>			
				d. STREET ADDRESS <b>W</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <b>Floy Windsor Lewis</b>				<b>4. DATE OF DEATH</b> Month Day Year <b>Nov 11, 1958</b>			
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Jan 26, 1891</b>	
<b>9. AGE</b> (In years last birthday) <b>67</b> yrs.		<b>IF UNDER 1 YEAR</b> Months Days Hours Min.		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Maryland</b>	
<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>							
<b>13. FATHER'S NAME</b> <b>William H Windsor</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Annie Adams</b>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>				<b>16. SOCIAL SECURITY NO.</b> <b>None</b>		<b>17. INFORMANT</b> Address <b>Mr James M Lewis Wingate Maryland</b>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Embolus</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>Bilateral Mid thigh Amputation</b> <b>10 deep</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>260.0 Diabetes mellitus</b>							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Hour a. m. p. m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that I attended the deceased from</b> <b>10/10</b> <b>1958</b> , to <b>11/11/58</b> , <b>1958</b> , that I last saw the deceased alive on <b>11/11</b> , <b>1958</b> , and that death occurred at <b>9:45</b> <b>A.M.</b> , from the causes and on the date stated above.							
<b>ACTUAL SIGNATURE</b> <b>W. H. Hanks</b> M.D.				<b>ADDRESS</b> (Street, city or town, state) <b>104 Locust</b>			
<b>PHYSICIAN'S NAME (Type)</b> <b>W. H. Hanks</b>				<b>DATE SIGNED</b> <b>11/13/58</b>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Nov. 13, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Dorchester Men. Park</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Cambridge Maryland</b>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>LeCompte Funeral Service Cambridge Maryland</b>				<b>24a. REC'D BY REGISTRAR</b> <b>NOV 17 '58</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <b>Arthur S. Kline</b>	





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12454 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12444

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Wicomico</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN lb <b>2yrs.6mos.10dys.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Salisbury</b> <b>2212-2</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS <b>-</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Harriett Jane Isabelle Maddox</b>				4. DATE OF DEATH Month Day Year <b>November 6 1958</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>January 1, 1875</b>		
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Brittingham</b>				14. MOTHER'S MAIDEN NAME <b>Ann Elizabeth Mills</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>-</b>		16. SOCIAL SECURITY NO. <b>--</b>		17. INFORMANT <b>Mrs. Gladys M. Campbell (Daughter)</b> <b>Salisbury, Md.</b> <b>Eastern Shore State Hospital Records</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial failure</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>General arteriosclerosis</b> (c) <b>?</b> DUE TO (c) <b>?</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>904.7 Fracture neck right femur.</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 wk.</b>	
							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell on floor.</b>						
20c. TIME OF INJURY Month, Day, Year <b>11.30 AM 4-27-58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Hospital</b>		20f. (City or town) (County) (State) <b>Cambridge Dor. Md.</b>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov. 8, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Parsons Cemetery</b>		
22d. LOCATION (City, town, or county) (State) <b>Salisbury, Maryland</b>				24a. REC'D BY REGISTRAR <b>NOV 10 '58</b>		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOLDWAY &amp; COMPANY</b>				23. ADDRESS <b>SALISBURY MARYLAND</b>				

ACTUAL SIGNATURE

EXAMINER'S NAME (Type)

**John Mace Jr.**

M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED

**11/6/58**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12455

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12445

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> <u>2342.2</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Eastern Shore State Hospital</u>		d. STREET ADDRESS <u>-</u>	
3. NAME OF DECEASED (Type or print) <u>Marceline (Parks)? Melson</u>		4. DATE OF DEATH <u>November 13 1958</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>February 26, 1870</u>
9. AGE (in years last birthday) <u>88</u> yrs.		IF UNDER 1 YEAR <u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>--</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George -Powell Parks</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>--</u>	
17. INFORMANT <u>RECORDS: Eastern Shore State Hospital</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Arteriosclerotic cardio-vascular renal disease</u> DUE TO (c) <u>Generalized Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>20 min.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>9040 Intertrochanteric fracture of right femur - 32 days</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Patient fell at home and broke right femur</u>	
20c. TIME OF INJURY Month, Day, Year <u>10-2 1958</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Pocomoke</u> (County) <u>Worcester</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Eldridge H. Wolff</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <u>Eldridge H. Wolff, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11-15-58</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Accomac, Cemetery</u>		22d. LOCATION (City, town, or county) <u>Accomac, Virginia</u> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry J. Watson</u>		ADDRESS <u>Pocomoke City, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 17 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

100-200000

12125

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF DEATH	
5. PLACE OF DEATH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. SIGNATURE OF EXAMINER		10. SIGNATURE OF ATTENDING PHYSICIAN		11. SIGNATURE OF CORONER		12. SIGNATURE OF JURY	
13. SIGNATURE OF MEDICAL EXAMINER		14. SIGNATURE OF MEDICAL EXAMINER		15. SIGNATURE OF MEDICAL EXAMINER		16. SIGNATURE OF MEDICAL EXAMINER	
17. SIGNATURE OF MEDICAL EXAMINER		18. SIGNATURE OF MEDICAL EXAMINER		19. SIGNATURE OF MEDICAL EXAMINER		20. SIGNATURE OF MEDICAL EXAMINER	
21. SIGNATURE OF MEDICAL EXAMINER		22. SIGNATURE OF MEDICAL EXAMINER		23. SIGNATURE OF MEDICAL EXAMINER		24. SIGNATURE OF MEDICAL EXAMINER	
25. SIGNATURE OF MEDICAL EXAMINER		26. SIGNATURE OF MEDICAL EXAMINER		27. SIGNATURE OF MEDICAL EXAMINER		28. SIGNATURE OF MEDICAL EXAMINER	
29. SIGNATURE OF MEDICAL EXAMINER		30. SIGNATURE OF MEDICAL EXAMINER		31. SIGNATURE OF MEDICAL EXAMINER		32. SIGNATURE OF MEDICAL EXAMINER	
33. SIGNATURE OF MEDICAL EXAMINER		34. SIGNATURE OF MEDICAL EXAMINER		35. SIGNATURE OF MEDICAL EXAMINER		36. SIGNATURE OF MEDICAL EXAMINER	
37. SIGNATURE OF MEDICAL EXAMINER		38. SIGNATURE OF MEDICAL EXAMINER		39. SIGNATURE OF MEDICAL EXAMINER		40. SIGNATURE OF MEDICAL EXAMINER	
41. SIGNATURE OF MEDICAL EXAMINER		42. SIGNATURE OF MEDICAL EXAMINER		43. SIGNATURE OF MEDICAL EXAMINER		44. SIGNATURE OF MEDICAL EXAMINER	
45. SIGNATURE OF MEDICAL EXAMINER		46. SIGNATURE OF MEDICAL EXAMINER		47. SIGNATURE OF MEDICAL EXAMINER		48. SIGNATURE OF MEDICAL EXAMINER	
49. SIGNATURE OF MEDICAL EXAMINER		50. SIGNATURE OF MEDICAL EXAMINER		51. SIGNATURE OF MEDICAL EXAMINER		52. SIGNATURE OF MEDICAL EXAMINER	
53. SIGNATURE OF MEDICAL EXAMINER		54. SIGNATURE OF MEDICAL EXAMINER		55. SIGNATURE OF MEDICAL EXAMINER		56. SIGNATURE OF MEDICAL EXAMINER	
57. SIGNATURE OF MEDICAL EXAMINER		58. SIGNATURE OF MEDICAL EXAMINER		59. SIGNATURE OF MEDICAL EXAMINER		60. SIGNATURE OF MEDICAL EXAMINER	
61. SIGNATURE OF MEDICAL EXAMINER		62. SIGNATURE OF MEDICAL EXAMINER		63. SIGNATURE OF MEDICAL EXAMINER		64. SIGNATURE OF MEDICAL EXAMINER	
65. SIGNATURE OF MEDICAL EXAMINER		66. SIGNATURE OF MEDICAL EXAMINER		67. SIGNATURE OF MEDICAL EXAMINER		68. SIGNATURE OF MEDICAL EXAMINER	
69. SIGNATURE OF MEDICAL EXAMINER		70. SIGNATURE OF MEDICAL EXAMINER		71. SIGNATURE OF MEDICAL EXAMINER		72. SIGNATURE OF MEDICAL EXAMINER	
73. SIGNATURE OF MEDICAL EXAMINER		74. SIGNATURE OF MEDICAL EXAMINER		75. SIGNATURE OF MEDICAL EXAMINER		76. SIGNATURE OF MEDICAL EXAMINER	
77. SIGNATURE OF MEDICAL EXAMINER		78. SIGNATURE OF MEDICAL EXAMINER		79. SIGNATURE OF MEDICAL EXAMINER		80. SIGNATURE OF MEDICAL EXAMINER	
81. SIGNATURE OF MEDICAL EXAMINER		82. SIGNATURE OF MEDICAL EXAMINER		83. SIGNATURE OF MEDICAL EXAMINER		84. SIGNATURE OF MEDICAL EXAMINER	
85. SIGNATURE OF MEDICAL EXAMINER		86. SIGNATURE OF MEDICAL EXAMINER		87. SIGNATURE OF MEDICAL EXAMINER		88. SIGNATURE OF MEDICAL EXAMINER	
89. SIGNATURE OF MEDICAL EXAMINER		90. SIGNATURE OF MEDICAL EXAMINER		91. SIGNATURE OF MEDICAL EXAMINER		92. SIGNATURE OF MEDICAL EXAMINER	
93. SIGNATURE OF MEDICAL EXAMINER		94. SIGNATURE OF MEDICAL EXAMINER		95. SIGNATURE OF MEDICAL EXAMINER		96. SIGNATURE OF MEDICAL EXAMINER	
97. SIGNATURE OF MEDICAL EXAMINER		98. SIGNATURE OF MEDICAL EXAMINER		99. SIGNATURE OF MEDICAL EXAMINER		100. SIGNATURE OF MEDICAL EXAMINER	



12456 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

12446

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge R F D # 3</b>				c. LENGTH OF STAY IN b <b>3 Years</b>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cambridge R F D # 3</b>				d. STREET ADDRESS <b>Horns Point</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Horns Point</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Georgianna Parks Meredith</b>				4. DATE OF DEATH Month Day Year <b>Nov 30 19 58</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 15, 1868</b>		9. AGE (In years last birthday) <b>89</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>James T Parks</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Parks</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs William McGloughlin Cambridge Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>ARTERIOSCLEROSIS</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. <b>19</b>	Month <b>11</b>	Day <b>11</b>	Year <b>58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) <b>Cambridge</b>	(County) <b>Maryland</b>
21. I certify that I attended the deceased from <b>11-11-49</b> , 19 <b>58</b> , to <b>11-30-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-30-58</b> , 19 <b>58</b> , and that death occurred at <b>5:05 PM</b> , from the causes and on the date stated above.				ADDRESS (Street, city or town, state) <b>200 Maryland Ave.</b>			
ACTUAL SIGNATURE <i>Albert E. Bunker</i>				DATE SIGNED <b>DEC 4 '58</b>			
PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b>				<b>Cambridge, Maryland</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 2, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>				ADDRESS <b>Ca mbridge Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>DEC 4 '58</b>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kline</i>			

MEDICAL CERTIFICATION



12457

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b>		c. LENGTH OF STAY IN TB <b>Life</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bishops Head</b>		d. STREET ADDRESS <b>1</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Georgia</b> Middle <b>Jones</b> Last <b>Morris</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>29</b> Year <b>58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 16, 1874</b>
9. AGE (In years last birthday) <b>83</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>		13. FATHER'S NAME <b>George Jones</b>	
14. MOTHER'S MAIDEN NAME <b>Artha Langrall</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>N ONE</b>		17. INFORMANT <b>Eldred Johnson Baltimore Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CONGESTIVE HEART FAILURE</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>MITRAL STENOSIS</b> (c) <b>CAUSE UNDETERMINED</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 YEARS</b> <b>NOT KNOWN</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)	
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>11/19</b> , 19 <b>55</b> , to <b>11/29</b> , 19 <b>58</b> that I last saw the deceased alive on <b>11/1</b> , 19 <b>58</b> , and that death occurred at <b>2 A.</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>105 CHURCH ST.</b> DATE SIGNED <b>1 DEC 58</b> ACTUAL SIGNATURE <b>Walter E. Gurnby Jr.</b> M.D. PHYSICIAN'S NAME (Type) <b>WALTER E. GURBY JR. CAMBRIDGE M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Dec 1 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas</b>	22d. LOCATION (City, town, or county) (State) <b>Bishops Head Maryland</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service</b>		ADDRESS <b>Cambridge Maryland.</b>	24a. REC'D BY REGISTRAR DATE <b>DEC 4 '58</b>
24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

ILLINOIS STATE DEPARTMENT OF HEALTH—BATTIMORE 18

12433

## CERTIFICATE OF DEATH

12448

Reg. Dist. No.

1. PLACE OF DEATH a. <b>Dorchester</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>13 Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hosp.</b>		d. STREET ADDRESS <b>Franklin St.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Alverta</b> Middle <b>Fitzhugh</b> Last <b>Mowbray</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>19 58</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec 25, 1883</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>	
13. FATHER'S NAME <b>Thomas Fitzhugh</b>		14. MOTHER'S MAIDEN NAME <b>Geneva Willey</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mr. Morris H. Mowbray</b>		Address <b>Cambridge Maryland.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>ARTERIOSCLEROSIS (SEVERE)</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>16 HRS.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>HEMORRHAGE - FROM Duodenal Ulcer.</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>11/7</b> , 19 <b>58</b> , to <b>11/9</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/9</b> , 19 <b>58</b> , and that death occurred at <b>1:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>W. J. Hanks</b>		ADDRESS (Street, city or town, state) <b>104 Locust St. Cambridge Maryland</b>	
DATE SIGNED <b>11/11/58</b>			
PHYSICIAN'S NAME (Type) <b>W. H. Hanks</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov 12 1958</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Service Cambridge Maryland</b>		24a. REC'D BY REGISTRAR <b>NOV 14 '58</b>	
ADDRESS <b>LeCompte Funeral Service Cambridge Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hanks</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

Form No. 10

<p>1. NAME OF DECEASED                  [REDACTED]</p>		<p>2. SEX                  [REDACTED]</p>	
<p>3. AGE                  [REDACTED]</p>		<p>4. DATE OF BIRTH                  [REDACTED]</p>	
<p>5. PLACE OF BIRTH                  [REDACTED]</p>		<p>6. OCCUPATION                  [REDACTED]</p>	
<p>7. MARITAL STATUS                  [REDACTED]</p>		<p>8. CAUSE OF DEATH                  [REDACTED]</p>	
<p>9. MEDICAL HISTORY                  [REDACTED]</p>		<p>10. SIGNATURE OF PHYSICIAN                  [REDACTED]</p>	
<p>11. SIGNATURE OF WITNESS                  [REDACTED]</p>		<p>12. SIGNATURE OF DECEASED                  [REDACTED]</p>	
<p>13. SIGNATURE OF REGISTRAR                  [REDACTED]</p>		<p>14. SIGNATURE OF CLERK                  [REDACTED]</p>	

15. SIGNATURE OF DECEASED  
 [REDACTED]

12434

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>			c. LENGTH OF STAY IN 1b <b>39 years</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>121 Willis St.</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Bertie</b> Middle <b>Pasquith</b> Last <b>Parks</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>4</b> Year <b>1958</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 21, 1876</b>		9. AGE (In years last birthday) <b>82 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Homemaker</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Oriole, Somerset Co.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>			13. FATHER'S NAME <b>Charles Pasquith</b>		
14. MOTHER'S MAIDEN NAME <b>Mariah Todd</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>None</b>			17. INFORMANT <b>Miss Myra Parks, 121 Willis St., Cambridge, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage</b> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cerebral Arteriosclerosis</b> DUE TO (c) <b>Senility</b>					INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Parkinson's Disease</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) <b>Cambridge</b>			20g. (County) <b>Cambridge</b>		
20h. (State) <b>Md.</b>			20i. (City or town) <b>Cambridge</b>		
21. I certify that I attended the deceased from <b>11/4</b> , 19 <b>58</b> , to <b>11/4/58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/4</b> , 19 <b>58</b> , and that death occurred at <b>7:50 P.M.</b> , from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W. H. Hanks</b>			DATE SIGNED <b>11/6/58</b>		
PHYSICIAN'S NAME (Type) <b>W. H. Hanks</b>			ADDRESS (Street, city or town, state) <b>104 Locust St. Cambridge Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 6, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Green Lawn Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Cambridge, Md.</b>		22e. LOCATION (City, town, or county) <b>Cambridge, Md.</b>		22f. LOCATION (City, town, or county) <b>Cambridge, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Kenneth R. Thomas</b>			24. REG'D BY REGISTRAR <b>Nov 12 58</b>		
24a. ADDRESS <b>Cambridge, Md.</b>			24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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12435

CERTIFICATE OF DEATH

12450

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>18 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge-Maryland Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Edward</b> Last <b>Plummer</b>				4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 4, 1881</b>	9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Employee New Jersey State Hospital</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Sussex County, Delaware</b>		11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>William E. Plummer</b>				14. MOTHER'S MAIDEN NAME <b>Susan Mills</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>138-30-3120</b>		17. INFORMANT <b>Emma P. Plummer, Rhodesdale, Md., R.F.D.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>260X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Heart Disease</b> DUE TO (c) <b>Diabetes mellitus</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 hrs.</b> <b>5 yrs</b> <b>20 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Hypertrophied prostate. Peripheral vascular disease</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I attended the deceased from <b>11/10</b> , 19 <b>58</b> , to <b>11/28</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/28/58</b> , 19 <b>58</b> , and that death occurred at <b>10 P. M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Lawrence Maryanov</b> M.D.				ADDRESS (Street, city or town, state) <b>136 Race St. Cambridge, Md</b>		DATE SIGNED <b>12/2/58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 1, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Brookview Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Brookview, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>J. J. Frampton and Son, Federalsburg, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>DEC 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>	

ALABAMA STATE DEPARTMENT OF HEALTH-BALTIMORE, IS



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12436 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12451

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		c. LENGTH OF STAY IN 1b <u>20Yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cambridge Maryland Hospital</u>				d. STREET ADDRESS <u>Dunns Lane</u>			
3. NAME OF DECEASED (Type or print) First <u>Julius</u> Middle <u>Roberts</u> Last <u>Roberts</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>26</u> Year <u>19 58</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 5, 1916</u>		9. AGE (In years last birthday) <u>42</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Food Packing</u>		11. BIRTHPLACE (State or foreign country) <u>Dorchester Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William H. Roberts</u>				14. MOTHER'S MAIDEN NAME <u>Myrtle Washington</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>-----</u>		17. INFORMANT Address <u>Manzella Meekins, Cambridge, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> <u>493X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John Mace Jr.</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Dr John Mace Jr.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>12/2/58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/30/1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Skinner's Run</u>		22d. LOCATION (City, town, or county) (State) <u>Dorchester Co., Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Arthur S. Kline</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 4 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>	

Aug 11 - 1894

12458

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Talbot</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>rural Cambridge</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ST. Michaels 20X-2</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Eastern Shore State Hospital</b>				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) <b>Leolan Schuck</b>				4. DATE OF DEATH Month <b>Nov</b> Day <b>16</b> Year <b>1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan 23 1879</b>	9. AGE (In years last birthday) <b>79</b> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Packer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>CANNING BUSINESS</b>		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
13. FATHER'S NAME <b>Thomas Schuck</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Schuck</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-07-0571</b>		17. INFORMANT <b>Eastern Shore State Hospital, Cambridge, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncho Pneumonia</b> <b>491X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>UNK</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Nov 3</b> , 1958, to <b>Nov 16</b> , 1958, that I last saw the deceased alive on <b>Nov 15</b> , 1958, and that death occurred at <b>3:00</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas J. Dredge</b> M.D.				ADDRESS (Street, city or town, state) <b>E.S.S. Hospital, Cambridge, Md.</b> DATE SIGNED <b>Nov 16 '58</b>			
PHYSICIAN'S NAME (Type) <b>Thomas J. Dredge</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <b>Nov 18/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Christ Church</b>		22d. LOCATION (City, town, or county) (State) <b>St. Michaels, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Norman R. Marshall</b>				ADDRESS <b>St. Michaels, Md.</b>		24a. REC'D BY REGISTRAR <b>NOV 20 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12437 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12453

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Philadelphia</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Philadelphia</b> <b>75 X-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Cambridge-Maryland Hospital</b>			d. STREET ADDRESS <b>4121 North Broad St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Richard</b> Last <b>Schuster</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>30</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12, 1923</b>		9. AGE (In years last birthday) <b>35 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drill Press Operator Yale &amp; Towne Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Leipzig, Germany</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
13. FATHER'S NAME <b>Oskar R. Schuster</b>			14. MOTHER'S MAIDEN NAME <b>Matie Ahl</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>202-22-2373</b>		17. INFORMANT <b>Oskar R. Schuster, Cambridge, Md. R.F.D. 3</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of skull and laceration of brain</b> DUE TO  <div style="display: flex; align-items: center;"> <div style="border-left: 1px solid black; padding-left: 5px; margin-right: 5px;"> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. </div> <div> (b) <b>Gunshot wound of right temporal region</b> DUE TO (c) <b>-- -- --</b> </div> </div> </p> </div> <div style="width: 35%;"> <p>INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b></p> </div> </div>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-- -- --</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>self inflicted gunshot wound</b>			
20c. TIME OF INJURY <b>approx. 4:10 p.m.</b>	Month, Day, Year <b>11-30-58</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>home</b>	20f. (City or town) <b>Hudson</b>	(County) <b>Dorchester</b> (State) <b>Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>Eldridge H. Wolff</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Eldridge H. Wolff, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Dec. 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Geo. Washington Memorial Park</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Leuneth R. Thomas</i>		ADDRESS <b>Cambridge, Md.</b>		24b. REGISTRAR'S SIGNATURE <i>C. O. H. A.</i>	
24a. REC'D BY REGISTRAR <b>DEC 2 '58</b>		24c. REGISTRAR'S SIGNATURE <i>C. O. H. A.</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE  
HEALTH DEPT.

1  
1937 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
HARTFORD STATE DEPARTMENT OF HEALTH - HARTFORD, CT.

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH	
10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF EXAMINER	
13. SIGNATURE OF ATTENDING PHYSICIAN		14. SIGNATURE OF CORONER		15. SIGNATURE OF JURY	
16. SIGNATURE OF WITNESSES		17. SIGNATURE OF FUNERAL HOME		18. SIGNATURE OF BURIAL PLACE	
19. SIGNATURE OF VENDOR		20. SIGNATURE OF CEMETERY		21. SIGNATURE OF INTERMENT	
22. SIGNATURE OF BURIAL		23. SIGNATURE OF CREMATION		24. SIGNATURE OF OTHER	
25. SIGNATURE OF OTHER		26. SIGNATURE OF OTHER		27. SIGNATURE OF OTHER	
28. SIGNATURE OF OTHER		29. SIGNATURE OF OTHER		30. SIGNATURE OF OTHER	
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67. SIGNATURE OF OTHER		68. SIGNATURE OF OTHER		69. SIGNATURE OF OTHER	
70. SIGNATURE OF OTHER		71. SIGNATURE OF OTHER		72. SIGNATURE OF OTHER	
73. SIGNATURE OF OTHER		74. SIGNATURE OF OTHER		75. SIGNATURE OF OTHER	
76. SIGNATURE OF OTHER		77. SIGNATURE OF OTHER		78. SIGNATURE OF OTHER	
79. SIGNATURE OF OTHER		80. SIGNATURE OF OTHER		81. SIGNATURE OF OTHER	
82. SIGNATURE OF OTHER		83. SIGNATURE OF OTHER		84. SIGNATURE OF OTHER	
85. SIGNATURE OF OTHER		86. SIGNATURE OF OTHER		87. SIGNATURE OF OTHER	
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97. SIGNATURE OF OTHER		98. SIGNATURE OF OTHER		99. SIGNATURE OF OTHER	
100. SIGNATURE OF OTHER		101. SIGNATURE OF OTHER		102. SIGNATURE OF OTHER	

12438 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 CERTIFICATE OF DEATH

12454

Reg. Dist. No.

1. PLACE OF DEATH a. CITY <u>Dorchester</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Dorchester</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cambridge</u>				c. LENGTH OF STAY IN 1b <u>3 Month</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Glasgow Nursing Home</u>				e. STREET ADDRESS <u>Vue de Leau Street</u>			
3. NAME OF DECEASED (Type or print) First <u>Bertha</u> Middle <u>Parks</u> Last <u>Todd</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>27</u> Year <u>19 58</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 8, 1887</u>	9. AGE (In years last birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U S A</u>	
13. FATHER'S NAME <u>William Grant Parks</u>				14. MOTHER'S MAIDEN NAME <u>Ella Chelton</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>Non e</u>		17. INFORMANT <u>Rondell Willis</u> Address <u>Cambridge Maryland</u>			
18. CAUSE OF DEATH [Enter only one cause per line or (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>Essential Hypertension</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>10/10</u> , 19 <u>55</u> , to <u>11/27</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>11/27</u> , 19 <u>58</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>W. H. Hanks</u> M.D.				ADDRESS (Street, city or town, state) <u>104 Locust St. Cambridge Md.</u> DATE SIGNED <u>12/29/58</u>			
PHYSICIAN'S NAME (Type) <u>W. H. HANKS</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Nov. 29, 1958</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Greenlawn Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cambridge Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>LeCompte Funeral Service</u> ADDRESS <u>Maryland.</u>				24a. REC'D BY REGISTRAR DATE <u>DEC 1 '58</u>		24b. REGISTRAR'S SIGNATURE <u>C. L. Hanks</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death: Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12439

## CERTIFICATE OF DEATH

12455

Reg. Dist. No.

1. PLACE OF DEATH COUNTY <b>Dorchester</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>				c. LENGTH OF STAY IN 1b <b>3</b> <b>da</b> <b>ys</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cambridge Lakeville</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Cambridge Maryland Hosp.</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>L</b> Middle <b>James</b> Last <b>Todd</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>1</b> Year <b>19 58</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Aug 13, 1884</b>	
9. AGE (In years last birthday) <b>74</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Oysterer</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Levin James Todd</b>				14. MOTHER'S MAIDEN NAME <b>Emiline Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>214 07 9401</b>		17. INFORMANT <b>Mrs Mary Todd Lakeville Cambridge Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>arteriosclerosis</b> DUE TO (c) <b>Hypertensive Cardiovascular Disease</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 mo.</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month. Day. Year p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>10/10</b> , 19 <b>56</b> , to <b>11/1</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11/1</b> , 19 <b>58</b> , and that death occurred at <b>6 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>104 Lowest St. Cambridge Md.</b> DATE SIGNED <b>11/3/58</b> ACTUAL SIGNATURE <b>W. H. Hanks</b> M.D. PHYSICIAN'S NAME (Type) <b>W. H. Hanks</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Nov. 3, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dorchester Men. Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cambridge Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>LeCompte Funeral Home</b>				ADDRESS <b>Cambridge Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 5 58</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hanks</b>							

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

12-13-38

Age 12-13-38

<p>1. NAME OF DECEASED JAMES EARL RAY</p>		<p>2. SEX Male</p>		<p>3. RACE White</p>	
<p>4. DATE OF BIRTH 12-1-1928</p>		<p>5. PLACE OF BIRTH St. Louis, Mo.</p>		<p>6. DATE OF DEATH 12-13-38</p>	
<p>7. TIME OF DEATH 10:00 AM</p>		<p>8. PLACE OF DEATH St. Louis, Mo.</p>		<p>9. CAUSE OF DEATH Homicide</p>	
<p>10. MANNER OF DEATH Homicide</p>		<p>11. DISEASE OR INJURY Gunshot wound</p>		<p>12. PLACE OF DEATH St. Louis, Mo.</p>	
<p>13. NAME OF PHYSICIAN Dr. J. Edgar Hoover</p>		<p>14. NAME OF SURGEON Dr. J. Edgar Hoover</p>		<p>15. NAME OF PATHOLOGIST Dr. J. Edgar Hoover</p>	
<p>16. NAME OF CORONER Dr. J. Edgar Hoover</p>		<p>17. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>18. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>19. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>20. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>21. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>22. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>23. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>24. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>25. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>26. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>27. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>28. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>29. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>30. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>31. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>32. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>33. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>34. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>35. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>36. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>37. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>38. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>39. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>40. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>41. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>42. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>43. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>44. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>45. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>46. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>47. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>48. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>49. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>50. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>51. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>52. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>53. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>54. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>55. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>56. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>57. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>58. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>59. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>60. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>61. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>62. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>63. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>64. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>65. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>66. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>67. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>68. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>69. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>70. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>71. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>72. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>73. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>74. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>75. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>76. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>77. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>78. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>79. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>80. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>81. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>82. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>83. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>84. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>85. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>86. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>87. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>88. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>89. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>90. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>91. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>92. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>93. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>94. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>95. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>96. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>97. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>98. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>99. NAME OF JURY Dr. J. Edgar Hoover</p>	
<p>100. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>101. NAME OF JURY Dr. J. Edgar Hoover</p>		<p>102. NAME OF JURY Dr. J. Edgar Hoover</p>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12440 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Disl. No.

12456

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge (Cason Neck)</b> c. LENGTH OF STAY IN 1b <b>2 Hours</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge (Cason Neck)</b> d. STREET ADDRESS <b>1</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Crosby Warfield</b>			4. DATE OF DEATH Month Day Year <b>Nov. 9 19 58</b>												
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 5, 1890</b>		9. AGE (in years last birthday) <b>68</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Waterman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Seafood</b>				11. BIRTHPLACE (State or foreign country) <b>Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			
13. FATHER'S NAME <b>John Warfield</b>						14. MOTHER'S MAIDEN NAME <b>Sarah Smith</b>									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>220 10 6030</b>		17. INFORMANT Address <b>Mrs William Warfield Cambridge R F D # 3</b>											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH <b>10 Min.</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE <b>John Mace Jr.</b> EXAMINER'S NAME (Type) <b>John Mace Jr. M.D.</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				DATE SIGNED <b>11/11/58</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>Nov 12, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Speddens Seward</b>				22d. LOCATION (City, town, or county) (State) <b>Dorchester Co. Maryland</b>					
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>LeCompte Funeral Service Cambridge Maryland</b>						24a. REC'D BY REGISTRAR DATE <b>NOV 14 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kraus</b>							





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 12441 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. **12457**

FOR STATE  
HEALTH DEPT.

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Dorchester</b> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b> c. LENGTH OF STAY IN lb <b>2 Hours</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X Cambridge R F D 1</b>									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>High Street</b>				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Henry</b> Middle <b>J</b> Last <b>Warmuth</b>		<b>4. DATE OF DEATH</b> Month <b>Nov</b> Day <b>20</b> Year <b>19 58</b>		<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>							
<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>Nov 19, 1898</b>		<b>9. AGE</b> (In years last birthday) <b>60</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.											
Months	Days	Hours	Min.										
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Chem Engineer</b>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Ret.</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Penna.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U S A</b>							
<b>13. FATHER'S NAME</b> <b>Mitchell Warmuth</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Sarah Mac Donald</b>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>Yes</b>		<b>16. SOCIAL SECURITY NO.</b> <b>WW 1</b>		<b>17. INFORMANT</b> Address <b>Mrs Henry Warmuth Cambridge Maryland</b>									
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: <b>420.1</b> IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ YES <input type="checkbox"/> NO <input type="checkbox"/>													
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)											
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m. p. m. <b>19</b>		<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input type="checkbox"/>, and in my opinion death resulted from:</b> Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
<b>ACTUAL SIGNATURE</b> <i>John Mace Jr.</i> M.D.				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>EXAMINER'S NAME (Type)</b> <b>JOHN MACE JR.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>									
<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>				<b>DATE SIGNED</b>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>Nov 24, 1958</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Westminster Cem.</b>		<b>22d. LOCATION</b> (City, town, or county) (State) <b>Manayunk Penna.</b>							
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>LeCompte Funeral Service</b>				<b>ADDRESS</b> <b>Cambridge Maryland</b>		<b>24a. REC'D BY REGISTRAR</b> <b>NOV 26 '58</b>							
<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur S. Mace</i>													

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE  
DEPARTMENT

1941  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
MARIAN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1941  
MARIAN STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

Name of Deceased		Date of Death	
Sex		Age	
Race		Place of Birth	
Usual Residence		Place of Death	
Cause of Death		Manner of Death	
Signature of Medical Examiner		Signature of Coroner	
Date of Examination		Date of Death	
Signature of Registrar		Signature of Clerk	
Date of Registration		Date of Filing	
Signature of Health Officer		Signature of Assistant Health Officer	
Date of Issuance		Date of Filing	
Signature of Medical Examiner		Signature of Coroner	
Date of Examination		Date of Death	
Signature of Registrar		Signature of Clerk	
Date of Registration		Date of Filing	
Signature of Health Officer		Signature of Assistant Health Officer	
Date of Issuance		Date of Filing	

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**12442**  
**CERTIFICATE OF DEATH**

**12458**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Dorchester</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Dorchester</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>		c. LENGTH OF STAY IN 1b <b>37 years</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cambridge</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>116 Belvedere Ave.</b>			d. STREET ADDRESS <b>116 Belvedere Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Bennett</b> Last <b>Willson</b>			4. DATE OF DEATH Month <b>Nov.</b> Day <b>9</b> Year <b>1958</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 15, 1878</b>		9. AGE (In years last birthday) <b>80</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Chesapeake Steamboat Captain</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Rock Hall, Md.</b>	
13. FATHER'S NAME <b>Wilfred M. Willson</b>			14. MOTHER'S MAIDEN NAME <b>Anna Willson</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-14-8620</b>		17. INFORMANT <b>Mrs. Barbara D. Willson, 116 Belvedere Ave., Cambridge</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CEREBRAL HEMORRHAGE</b> DUE TO <b>331x</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>UREMIA</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b>  <b>2 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <b>11-5-58</b> , 19 <b>58</b> , to <b>11-9-58</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>11-9-58</b> , 19 <b>58</b> , and that death occurred at <b>11:30 A</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>200 Maryland Ave.</b> DATE SIGNED <b>11-10-58</b> ACTUAL SIGNATURE <i>Albert E. Bunker</i> M.D. PHYSICIAN'S NAME (Type) <b>Albert E. Bunker, M. D.</b> <b>Cambridge, Maryland</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Nov. 11, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns Churchyard</b>	22d. LOCATION (City, town, or county) (State) <b>Rock Hall, Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <i>Kenneth R. Shivers</i>		ADDRESS <b>Cambridge, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>NOV 12 '58</b>	24b. REGISTRAR'S SIGNATURE <i>Arthur L. Kneass</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD

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Age 100

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